

NEW JERSEY DEPARTMENT OF COMMUNITY AFFAIRS
Division of Housing and Community Resources

Health and Safety Client Intake Survey

Client Name: _____ **File ID:** _____

Address: _____

Date of Initial Survey: ____/____/____ **Date of Onsite Survey:** ____/____/____

The New Jersey Weatherization Assistance Program (NJ WAP) assists low-income homeowners and tenants with making their homes more energy efficient, thereby increasing their comfort and saving money on energy bills. In the process, we work to ensure their health and safety to the best of our ability.

As a client in the NJ WAP, I understand that my health and safety, and that of the NJ WAP staff and contractors is a critical component of the NJ WAP and that any and all weatherization activities, retrofit materials, techniques or practices will be conducted to minimize any health and safety concerns and negative environmental impacts.

To be completed at client eligibility intake and confirmed with follow up during home assessment.

To provide safe and effective services, it is necessary to understand occupant health conditions and potential health concerns within the home. Please check the appropriate boxes below and provide details in the space provided.

___ Has anyone in the household tested positive for COVID-19? ___yes or ___no

If yes, how long ago? _____

___ Has anyone in the household experienced fever, cough or shortness of breath in the last two weeks?

___yes or ___no

___ Has anyone in the household been in contact with someone who has tested positive or experiencing the above symptoms? ___yes or ___no If yes, how long ago _____

___ Does anyone in the household have underlying medical conditions or are they in frequent contact with someone who has underlying medical conditions? ___yes or ___no

___ Chronic allergies: _____

___ Breathing problems: _____

___ High blood lead levels: _____

___ Wheelchair or accessibility needs: _____

___ Mold or moisture problems in home (specify location): _____

___ Lead or asbestos in home (specify location): _____

___ Known radon test levels: _____

___ Other concerns: _____

Identified actions that may be necessary to assure the health and safety of clients based on occupant preexisting health conditions (auditor note the planned use spray foam and any additional precautions to be taken):

Intake Specialist Signature: _____ **Date:** ____/____/____

Auditor/Assessor Signature: _____ **Date:** ____/____/____

Please contact your local WAP agency if you have any questions or concerns about the work being performed in your home.